Original Article

The Right to Say No: Why Adult Sexual Assault Patients Decline Medical Forensic Exams and Sexual Assault Kit Evidence Collection

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Introduction: The International Association of Forensic Nurses (2018) affirms the importance of evidence-based, trauma-informed, patient-centered forensic nursing services that engage patients as autonomous decision makers. Past research indicates that forensic nurses consistently respect patients' choices and control as they navigate the decisions of medical forensic examinations (MFEs) and sexual assault kit (SAK) collection. Building on that work, this study examined which options patients decline and what factors are associated with those declination decisions.

Method: We collected prospective data from seven state-funded sexual assault nurse examiner programs. Forensic nurses recorded information about all adult sexual assault patients (N = 783) regarding four primary decisions: whether to have a MFE, whether to consent to all parts of the MFE or to decline specific services, whether to have a SAK collected, and whether to release the SAK to law enforcement for forensic DNA testing.

Results: Most patients consented to a MFE (95%), to all parts of the MFE (81%), to SAK collection (99%), and to release the SAK for forensic DNA testing (80%). Younger patients and those with disabilities were more likely to decline some options. Patients who had not disclosed the assault to others before seeking sexual assault nurse examiner care were also more likely to decline a MFE. Whether patients sought post assault care for more health-focused reasons or legally focused reasons was associated with declination decisions.

Conclusions: Healthcare providers should communicate clearly about each step in post assault care and allow patients to decline services as they choose.

KEY WORDS:

Medical forensic examinations; sexual assault; sexual assault kits; sexual assault nurse examiners

Patient-centered practice is fundamental to the care of sexual assault patients, as recognized by national and international practice and policy leaders. The Department of Justice (DOJ, 2013) national protocol for sexual assault medical forensic examinations (MFEs) states:

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> Sexual assault victims are central participants in the medical forensic exam process, and they deserve timely, compassionate, respectful, and appropriate care. Victims have the right to be fully informed in order to make their own decisions about participation in all components of the exam process. Responders need to do all that is possible to explain possible options, the consequences of choosing one option over another, and available resources, as well as support victims in their choices. (pp. 18–19)

Likewise, the core value statement of the International Association of Forensic Nurses (2018) affirms the discipline's commitment to "ensuring access to evidence-based, trauma-informed, patient-centered forensic nursing services." Moreover, in the newly updated Constructed Theory of Forensic Nursing Care, Valentine et al. (2020) highlight that forensic nursing services are inherently multifaceted to promote positive health, forensic, and legal outcomes, and nurses must empower patients' choices in all of these domains. Taken together, these three guidepost documents underscore forensic nursing's commitment to engaging patients as autonomous decision makers. Providing clear, accurate information helps empower patients to make informed decisions about their care.

Sexual assault survivors who seek post assault health care are faced with numerous decisions. The initial choice to have a sexual assault MFE cascades quickly to a series of increasingly complex choices survivors must make regarding examination procedures (e.g., the use of a speculum), treatment options (e.g., emergency contraception), and documentation (e.g., forensic photography). Patients also must decide whether they want to have a sexual assault kit (SAK) collected to preserve medical forensic evidence for possible criminal justice investigation and prosecution. In a growing number of states, patients have a separate decision whether to release the SAK to law enforcement personnel for forensic DNA testing. Even in a setting of compassionate, patient-centered care, the sheer number of decisions sexual assault patients face is staggering.

In the context of MFEs performed in sexual assault nurse examiner (SANE) programs, prior quantitative research indicates that forensic nurses consistently respect patients' choices and autonomy as they navigate these difficult decisions. In one of the largest-scale studies to date on specialized forensic nursing programs, Du Mont et al. (2014) surveyed 1,484 patients treated in one of 30 Canadian forensic nursing care programs located in the province of Ontario, and found that nearly all patients indicated they received the care needed (98.6%), rated that care as excellent or good (98.8%), stated that the care had been provided in a sensitive manner (95.4%), and affirmed they were able to choose their preferred care (94.8%). In a smaller-scale quantitative study with a U.S. SANE program, Campbell et al. (2008) asked 52 patients how nurses empowered their choices and control during the MFE. All patients (100%) stated that their nurses explained what was going to happen next in the examination, and all (100%) said they knew they could take a break or say no to any part of the examination. Most patients (71%) felt they had complete control during the examination, and 100% stated they felt completely informed during the examination.

Qualitative research also affirms that patients who seek post assault health care in SANE programs feel that practitioners respect their agency throughout the examination process. For example, Ericksen et al. (2002) interviewed eight adult sexual assault patients who sought care from a Canadian specialized sexual assault treatment center, and in these narratives, patients emphasized that they were treated with dignity and respect and felt they were given options and were not pushed toward certain choices. In qualitative interviews with 20 adult sexual assault survivors who sought care from a U.S. midwestern SANE program, Fehler-Cabral et al. (2011) identified three key themes in patients' stories about their MFE experiences: (a) They were provided a clear and thorough explanation of the examination process and findings, (b) they were given choices during the examination, and (c) they were treated with care and compassion. Patients appreciated how nurses explained it was their choice to have the examination at all, and they could decline parts of the examination and control what information would be disclosed to whom and for what purposes.

Although prior research indicates that sexual assault patients often feel autonomous for healthcare-focused components of the MFE, the legal components of the examination and SAK evidence collection process create challenges and tensions. For example, in Campbell et al.'s (2008) quantitative survey project, 70% of patients stated they felt no pressure from their nurses to engage in criminal investigation and prosecution, but 30% felt at least some pressure from their nurses to pursue legal options. Likewise, in the qualitative Fehler-Cabral et al. (2011) study, six of the 20 patients interviewed stated that the SAK evidence collection process was upsetting, and although the nurses did not make them participate in the SAK evidence collection process, they did not feel like it was truly and fully their choice to do so. Corrigan's (2013) qualitative ethnographic study of post assault medical forensic care services in the United States found that police specifically tell victims they have to have an MFE and SAK collection if they want the option of reporting and prosecuting the assault, and consenting to these services is viewed as a test of victims' seriousness and credibility. If victims want law enforcement to take their case seriously, patients do not truly have a choice about MFEs and SAKs, and Corrigan found that nurses communicated that reality and necessity to their patients. Consequently, survivors felt they had to consent to evidence collection and forensic photography, which they often described as highly invasive and

upsetting, even if they did not want to because they wanted to preserve the option of legal prosecution (Brennan, 2006; Corrigan, 2013; Greeson & Campbell, 2011; Mulla, 2011, 2014; Spangaro et al., 2015; White & Du Mont, 2009).

The extent to which patients feel they can decline any component of the MFE or SAK and that such choices would be supported by their nurses is critical for the provision of trauma-informed, patient-centered care. To inform practice, a key next step for research is to examine the major decision points patients face in MFEs and SAKs and to document rates and reasons for declination of services. Previous research has documented rates of service provision in forensic nursing programs (Du Mont et al., 2014), and to build on that work, our goal in this study was to understand which options patients decline and what factors are associated with those declination decisions. To that end, we conducted a large-scale, multisite quantitative study with seven midwestern SANE programs to document adult sexual assault patients' decisions in regard to four primary choices: whether to have a MFE, whether to consent to all parts of the MFE or to decline specific services, whether to have a SAK collected, and whether to release the SAK to law enforcement for forensic DNA testing. These are by no means the only decisions patients must make in post assault health care, but they are fundamental choice points that have important health and legal implications for patients and thus are key opportunities for nurses to support patient-centered practice. In this study, we documented rates and reasons patients declined each of these four decisions and then statistically evaluated how demographic characteristics, assault characteristics, disclosure experiences, and reasons for seeking post assault health care were associated with patients' decisions on these four choice points.

Method

Sample

To collect data about adult sexual assault patients' decisions regarding MFEs and SAKs, we partnered with all SANE programs in one large midwestern state that receive state/federal funding for sexual assault patient examinations and advocacy services ($N = 7$ programs). The vast majority of MFEs in this state are performed by healthcare practitioners in these seven programs (82% per state funder records), so collaborating with these SANE programs provides a comprehensive, although not exhaustive, statewide assessment of adult patients' experiences seeking MFEs. Table 1 describes the community context and program structure of these seven sites, which include large urban, suburban, midsized urban, and rural programs. Healthcare practitioners in these seven programs recorded de-identified information about each adult sexual assault patient aged 18 years or older who sought post assault health care at their program during the data collection period: $N = 783$ adult sexual assault patients. We acknowledge that the DOJ (2013) national MFE protocol defines patient populations and examination procedures based on age of menarche, but for this study, we defined "adult" as aged 18 years or older to be consistent with institutional review board (IRB) research regulations.

Procedures

To protect patient privacy and to comply with Health Insurance Portability and Accountability Act (HIPPA) regulations and client confidentiality provisions of federal Victims of Crime Act and Violence Against Women Act (VAWA) funding, the research team was not permitted access to patient files to review and code information for research purposes. Therefore, we worked collaboratively with healthcare practitioners in all seven SANE programs, their state funders, and our IRB to develop alternative data collection procedures. Collectively, we agreed it would be feasible for healthcare practitioners to complete a separate standardized research form about each patient after they had finished patient care and their normal program charting documentation. HIPAA, VAWA, and IRB regulations necessitate de-identified data collection, so the amount of information and level of detail that could be recorded about each case on these forms would need to be limited to protect patient privacy (see Measures below). We pilot tested these procedures with two sites for 1 month to gather staff feedback on the content of the data collection form and to identify potential problems with the collection and storage of the forms. Once we had finalized procedures and measures, we conducted in-person trainings with staff in all seven programs to ensure standardized implementation, and we also provided supplemental video trainings so staff could rereview training content as needed. Throughout data collection, we engaged in both in-person and remote supervision to monitor fidelity to the protocol and to check forms for completeness. These procedures were approved by the IRB of Michigan State University.

Measures

The data collection form prompted healthcare practitioners to record the following demographic information about each patient: gender, race, age, and disability status (physical, developmental/cognitive, mental health, multiple disabilities). Limited information about the sexual assault incident itself was captured to protect patient privacy (see above), so practitioners only recorded victim–offender relationship (coded as "stranger/just met," "acquaintance/family/intimate partner," "unsure," or "patient did not provide offender identity information/other") and the time between the assault and when the MFE was conducted (coded as "within 24 hours of the assault," "24–48 hours post assault," "48–72 hours post assault," "72 hours to 1 week post assault," and "more than 1 week post assault"). The data collection form captured information about patients' disclosures of the assault, noting who they

TABLE 1. Data Collection Sites: Seven State-Funded Sexual Assault Nurse Examiner Programs

Site	Program description	Current study sample (*N* = 778)
1	A large urban decentralized SANE program. Forensic examiners travel to three hospital emergency departments and one clinic site to conduct MFEs.	41%
2	A medium-sized urban centralized SANE program within a domestic violence/sexual assault (DV/SA) agency. MFEs conducted at the agency's SANE clinic.	17%
3	A small rural centralized SANE program within DV/SA agency. MFEs conducted at a community clinic setting.	2%
4	A large suburban decentralized SANE program. Forensic examiners travel to one hospital emergency department and one clinic site to conduct MFEs.	11%
5	A small rural centralized SANE program within DV/SA agency. MFEs conducted at a community clinic setting.	2%
6	A small rural decentralized SANE program. Forensic examiners travel to five hospital emergency departments and one clinic site to conduct MFEs.	14%
7	A large suburban centralized SANE program within a DV/SA agency. MFEs conducted at the agency's SANE clinic.	13%

had told about the assault before seeking care at the SANE program, categorized as (a) an advocate, (b) law enforcement personnel, (c) intimate partner, (d) family/friend, (e) other person, (f) no prior disclosures, or (g) patient declined to provide information about prior disclosures (each option coded 1 = *yes* and 0 = *no*).

Program staff recorded information about four focal decisions patients must make when seeking post assault health care. First, healthcare practitioners noted whether each patient "consented to having an MFE" (coded 1 = *yes* and 0 = *no*). SANE program staff also recorded "patients' stated reasons for seeking an MFE," categorized as (a) concerns about physical injuries, (b) concerns about sexually transmitted infections, (c) concerns about pregnancy, (d) patient wanted DNA collection to identify/confirm identity of offender, (e) patient wanted to pursue criminal investigation, (f) patient was unsure what had happened to them and wanted to know whether an assault happened, and (g) someone suggested/instructed the patient to have an examination (each coded 1 = *yes* and 0 = *no*).

Second, program staff noted whether the patient "declined any portion of the MFE" (coded 1 = *yes* and 0 = *no*). The data collection form prompted providers to write in (free response) what parts of the MFE were declined. The research team reviewed and categorized the data as (a) the anogenital examination, (b) the use of a speculum in the examination, (c) forensic photography, or (d) other, with space for practitioners to list what was declined (each coded 1 = *yes* and 0 = *no*).

Third, healthcare providers recorded whether each patient "consented to have an SAK collected" to preserve medical forensic evidence of the assault (coded 1 = *yes* and 0 = *no*). For those who declined SAK evidence collection, practitioners noted patients' stated reasons for this decision, categorized as (a) patient did not want to go through evidence process (e.g., too tired, upset), (b) patient did not want to pursue a criminal investigation, (c) patient stated other reasons, or (d) patient did not specify a reason (each coded 1 = *yes* and 0 = *no*).

Fourth, in the state in which this study was conducted, there is a separate consent process for the release of a completed SAK to law enforcement for forensic DNA testing; therefore, SANE program staff recorded whether each patient "released the SAK to law enforcement" (coded 1 = *yes* and 0 = *no*). For patients who decided not to release the SAK for testing, practitioners listed their stated reasons for that decision, categorized as (a) patient wanted more time to consider options, (b) patient did not feel she/he/they were able to make a decision in that emotional state, (c) patient did not want to interact with law enforcement or pursue a criminal investigation, (d) patient stated other reasons, or (e) patient did not specify a reason (each coded 1 = *yes* and 0 = *no*).

Analysis Plan

We began our analyses by examining the extent of missing data on the four focal patient decision variables ("consent to MFE," "decline any portion of MFE," "consent to SAK collection," and "release of SAK to law enforcement"). Of the *N* = 783 cases, *n* = 5 had missing data on the first decision point—whether the patient consented to an MFE. This is a critical variable as all other questions cascade from this first fundamental decision, but we felt data imputation was not a good strategy to resolve missing data because such methods would be estimating factual information about healthcare treatment. Therefore, we decided to remove those five cases from the data set, and our final sample size for data analysis was *N* = 778. Working from that sample of *N* = 778, we tracked patients' decisions on the three remaining questions (i.e., "decline any portion of MFE," "consent to SAK collection," and "release of SAK to law enforcement"). There were some missing data on those variables because of incomplete data collection by program staff; in addition, after data collection was complete, we discovered an error in the skip

patterns on the data collection form that created some additional missing data on one of those questions ("decline any part of MFE"). The skip pattern error applied only in rare circumstances, so it did not produce substantial missing data. Overall, the amount of missing data on these three variables was minimal (<5%) and therefore did not require formal missing data analysis (Tabachnick & Fidell, 2013). For transparency, we report raw response counts (i.e., the number of cases that were "yes" or "no" or missing for each decision point), but consistent with the recommendations of Tabachnick and Fidell (2013), we report valid percentages, which exclude missing cases on an item-by-item basis. We used R Version 3.6.1 (R Development Core Team, 2019) and SPSS Version 25 to conduct descriptive analyses (unconditional and conditional percentages, means, and standard deviations) for all focal variables and univariate inferential tests to explore whether patients' decisions regarding MFEs, SAK collection, and SAK release varied as a function of demographic, assault, and disclosure variables.

Results

Most patients who sought post assault care in these seven SANE programs were women (94%), and 56% were White, 33% were Black, 5% were Latinx/Hispanic, and 6% were other races/ethnicities (e.g., Native American, Asian, multiracial, other). The median age of this sample was 26 years. One third (33%) of the patients had a disability (physical, developmental, cognitive, and/or mental health). Consistent with national epidemiological data (Planty et al., 2016), most patients were sexually assaulted by someone they knew: 54% were assaulted by an acquaintance, family member, or intimate partner; 37% were assaulted by a stranger or someone they had just met; 6% were unsure who had assaulted them; and 3% did not provide offender identity information to SANE program staff. Most patients sought care within 24 hours of the assault (66%), and 18% sought care between 24 and 48 hours, 8% sought care between 48 and 72 hours, 7% sought care between 72 hours and 1 week, and <1% sought care beyond 1 week of the assault. Before seeking care at one of these SANE programs, most patients had disclosed the assault to others: 16% had told an advocate, 57% had already had contact with law enforcement about the assault, 13% had disclosed to their intimate partner, 57% had told a family or friend, and 5% had disclosed to someone else (e.g., social worker/case worker, counselor/therapist, school/college personnel; numbers sum to more than 100% as patients may have disclosed to multiple people). Three percent of the patients had told no one about the assault before seeking care at a SANE program.

Figure 1 depicts the number of patients who consented to each of the four focal decision points in the MFE-SAK process. As shown at the top left of this figure, of the $N = 778$ patients in our final analysis sample, 738 (95%) consented to the MFE and 40 declined the MFE (5%). Although the vast majority of patients did consent to an MFE, we explored

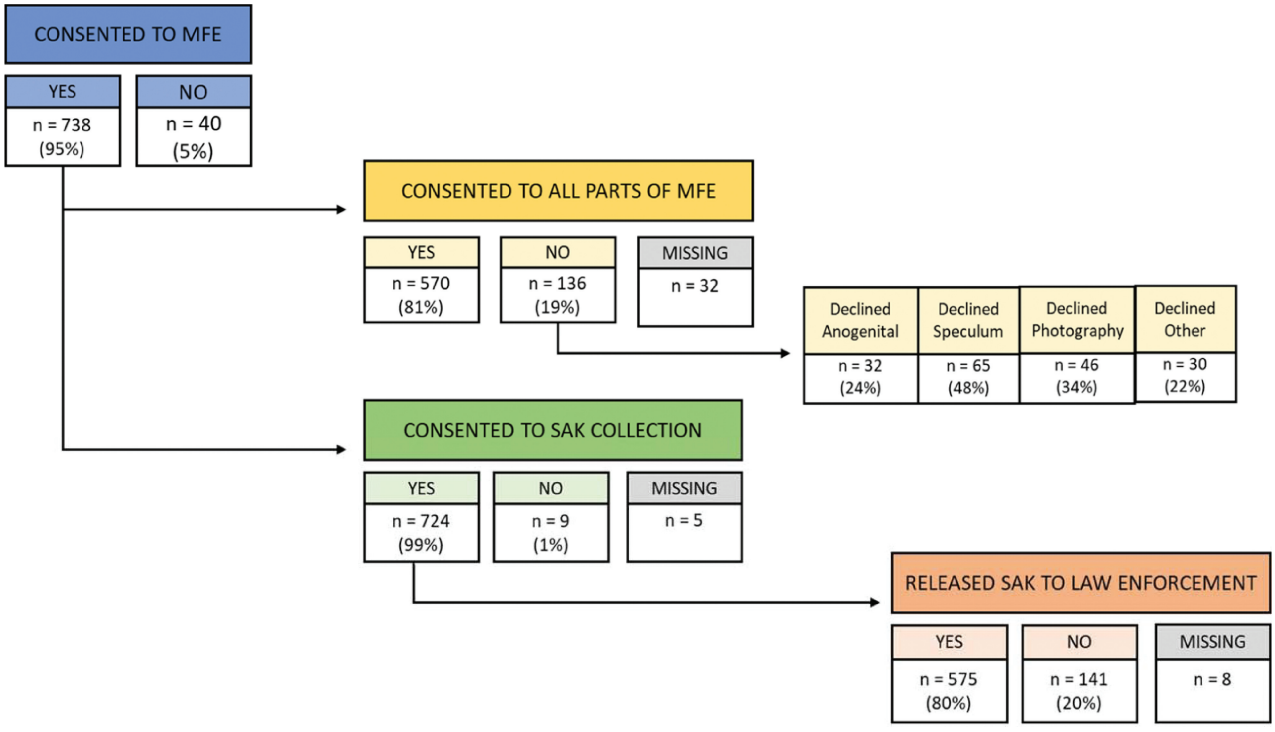

FIGURE 1. Adult sexual assault patients' decisions regarding medical forensic examinations and sexual assault kit collection and release.

what factors differentiated the 5% who declined this service, and Table 2 summarizes the significant findings. There were no demographic characteristics that distinguished those who did and did not consent to an MFE. With respect to assault characteristics, patients who did not provide information to their healthcare practitioners about the identity of the offender were significantly more likely to decline the MFE. There were no significant differences between those who did and did not consent to an MFE with respect to the time between the assault and when they sought care at one of these SANE programs. As shown in Table 2, victims' disclosure histories were significantly associated with their decisions whether to have an MFE: Those who declined the examination were less likely to have disclosed to an advocate, the police, an intimate partner, and/or a family member or friend. Those who declined the examination were more

TABLE 2. Factors Associated With Patients' Decisions to Consent to a Medical Forensic Examination (MFE)

	Consented to MFE		Did not consent				
Variable	**%**	***n***	**%**	***n***	χ^2	***df***	***p***
Demographic characteristics							
No significant effects							
Assault characteristics							
Victim–offender relationship					117.13	3	<.001
Stranger/just met	96.13	273	3.87	11			
Friend/family/ dating	96.91	408	3.09	13			
Unsure	93.75	45	6.25	3			
Other/did not provide	45.45	10	54.55	12			
Disclosure of assault before seeking health care							
Disclosed to advocate					4.07	1	<.05
Yes	99.17	119	0.83	1			
No	94.34	617	5.66	37			
Disclosed to law enforcement					6.03	1	<.05
Yes	96.85	430	3.15	14			
No	92.73	306	7.27	24			
Disclosed to intimate partner					4.76	1	<.05
Yes	100.00	102	0.00	0			
No	94.49	634	5.51	37			
Disclosed to family/friend					12.79	1	<.001
Yes	97.72	429	2.28	10			
No	91.92	307	8.08	27			
Any prior disclosure					17.20	1	<.001
Yes	95.73	718	4.27	32			
No	75.00	18	25.00	6			
Reasons for seeking health care							
Injuries					6.89	1	<.01
Yes	98.91	182	1.09	2			
No	93.70	550	6.30	37			
DNA collection					12.96	1	<.001
Yes	99.56	226	0.44	1			
No	93.01	506	6.99	38			
Pursue criminal investigation					20.30	1	<.001
Yes	99.37	314	0.63	2			
No	91.87	418	8.13	37			

likely to have told no one about the assault before seeking care at the SANE program. Table 2 also denotes that the reasons why patients sought SANE care was related to their decision whether to consent to an MFE: Those who declined the examination were less likely to express concerns about injuries and were less likely to state that they were seeking care for DNA evidence collection and to pursue criminal investigation of the assault.

Healthcare practitioners also recorded whether those who consented to an MFE consented to all parts or whether they declined some portions of the examination. Referring back to the middle of Figure 1, of the 738 patients who consented to an MFE, 136 (19%) declined some portion of the examination. Of those patients who declined any part of the examination, nearly half (48%) declined the use of a speculum during the examination, approximately one third (34%) declined to have anogenital/body photographs taken, and nearly one quarter (24%) declined to have an anogenital examination (see Figure 1; percentages do not sum to 100 because some patients declined more than one component). We compared those who consented to all parts of the MFE and those who declined any part of the examination, and the significant findings are summarized in Table 3. Younger patients were significantly more likely to decline parts of the MFE, as were those who sought health care more than 1 week after the assault. There were no significant differences between those who consented to all parts of the examination and those who declined parts based on their disclosure histories, but their reasons for seeking the examination were distinguishing factors. Specifically, patients who sought SANE care because they were concerned about the risk of pregnancy were more likely to decline some parts of the examination. Patients who were not interested in pursuing a criminal investigation were more likely to decline some parts of the examination, as were those who sought SANE care because someone else suggested or told them they needed an MFE.

Returning to Figure 1 (middle), the overwhelming majority of patients who consented to an MFE also consented to the collection of an SAK (99%). Of the $n = 9$ patients who declined SAK collection, four indicated that they did not want to go through the evidence collection process (33% of those who declined), two stated that they did not want to pursue a criminal investigation (17% of those who

TABLE 3. Factors Associated With Patients' Decisions to Decline Parts of the Medical Forensic Examination

Variable	All parts completed		Patient declined any part		χ^2	*df*	*p*
	%	*n*	%	*n*			
Demographic characteristics							
Age (median), years	–	26	–	24	8.17	1	<.01
Assault characteristics							
Time since assault					12.80	4	<.05
<24 hours	80.00	368	20.00	92			
24–48 hours	80.92	106	19.08	25			
48–72 hours	78.33	47	21.67	13			
72 hours to 1 week	92.00	46	8.00	4			
>1 week	0.00	0	100.00	2			
Disclosure of assault before seeking health care							
No significant effects							
Reasons for seeking health care							
Pregnancy					7.14	1	<.01
Yes	71.00	71	29.00	29			
No	82.86	498	17.14	103			
Pursue criminal investigation					12.21	1	<.001
Yes	87.21	266	12.79	39			
No	76.52	303	23.48	93			
Someone suggested/instructed patient to have examination					4.13	1	<.05
Yes	75.16	115	24.84	38			
No	82.85	454	17.15	94			

declined), three stated other reasons (e.g., unable to give consent because of mental state, did not want to learn the identity of the offender; 25% of those who declined), and four did not provide a reason (33% of those who declined; raw counts and percentages total more than $n = 9$ and 100%, respectively, because patients who stated a reason provided multiple reasons for declining a SAK). Table 4 summarizes what factors distinguished those who did not consent to a SAK. Patients' decisions to have a SAK collected did not vary as a function of demographics, assault characteristics, or assault disclosures. Patients' reasons for seeking an examination were related to their decisions regarding SAK collection: Of the nine patients who did not consent to SAK collection, none of them cited pursuing a criminal investigation as a reason for seeking SANE care.

Finally, as shown in Figure 1 (lower right), most survivors who had a SAK collected consented to its release to law enforcement for forensic DNA testing ($n = 575$, 80%). Of the $n = 141$ patients who did not release their kits, 65% wanted more time to consider their options, 19% stated that they were unable to make a decision at that point given their emotional state, 14% did not want to interact with law enforcement personnel, 25% stated some other reason (e.g., prior negative experiences reporting a sexual assault, did not want others in their life to know about the assault), and 33% did not give a reason (percentages do not sum to 100% because patients cited multiple reasons). Table 5 summarizes what factors significantly distinguished those who did and did not release SAKs to the police for forensic DNA testing. Patients who decided not to release their kits were less likely to be Black or to have a disability; put another way, Black patients (relative to patients of all other races) and those with disabilities (relative to those without disabilities) were significantly more likely to release SAKs to law enforcement. Younger patients were significantly less likely to release SAKs for forensic DNA testing. Patients who sought MFEs beyond 24 hours after the assault were also less likely to consent to SAK release. Preexamination disclosures were influential, as those who had not disclosed to the police were less likely to release the kit; put another way, those who had contacted the police before seeking care at the SANE program were significantly more likely to release their kits. Those who had disclosed the assault to family or friends and those who had not disclosed to anyone before seeking care were less likely to release their kits for forensic DNA testing. The reasons why patients sought post assault health care was related to their decisions to release kits to the police: Those who sought post assault health care for concerns about sexually transmitted infections and pregnancy were less likely to release their kits to the police. Patients who did not release their kits were less likely to state that they had sought SANE care because they wanted DNA collection or that they wanted to pursue criminal investigation (and those who sought care for those legally focused reasons were more likely to release SAKs to the police).

TABLE 4. Factors Associated With Patients' Decisions to Consent to Sexual Assault Kit (SAK) Collection

	Consented to SAK Collection		Did Not Consent				
Variable	%	*n*	%	*n*	χ^2	*df*	*p*
Demographic characteristics							
No significant effects							
Assault characteristics							
No significant effects							
Disclosure of assault before seeking health care							
No significant effects							
Reasons for seeking health care							
Pursue criminal investigation					5.23	1	<.05
Yes	100.00	313	0.00	0			
No	97.83	405	2.17	9			

Discussion

In the aftermath of sexual assault, victims face complex decisions that can have long-lasting health and legal consequences (Valentine et al., 2020). Victims must navigate these choices amid tremendous emotional and physical distress, and thus, it is critical that patients have appropriate information and support about their options. To that end, the discipline of forensic nursing emphasizes that sexual assault victims are autonomous decision makers and healthcare practitioners must help victims regain a sense of safety, bodily autonomy, and control (DOJ, 2013; IAFN, 2018; Valentine et al., 2020). Some patients accept all services provided by forensic nurses, but others may decline specific health, forensic, and/or legal options. Our goal in this study was to explore why patients may opt out of four key decisions: having an MFE, completing all parts of the MFE, consenting to SAK collection, and releasing kits to the police for forensic testing. Overall, our results indicate that the vast majority of patients do consent to all of these services However, because respecting patient choice is fundamental to trauma-informed care, it is important to understand why some patients may decline certain services.

Key Findings, Limitations, and Future Research

In this study, 95% of the adult sexual assault patients who sought care in one of seven state-funded SANE programs consented to an MFE. Whether patients had disclosed the assault to others before seeking SANE care was a key factor associated with the decision to have an MFE. Patients who had not disclosed the assault to anyone else before contacting a

TABLE 5. Factors Associated With Patients' Decisions to Release Sexual Assault Kit (SAK) to Law Enforcement

Variable	Released SAK		Did not release SAK		χ^2	*df*	*p*
	%	*n*	%	*n*			
Demographic characteristics							
Race					14.99	3	<.01
White	76.94	297	23.06	89			
Black	88.28	211	11.72	28			
Hispanic/Latinx	72.97	27	27.03	10			
Other	73.17	30	26.83	11			
Age (median), years	–	27	–	24	11.48	1	<.001
Disability					15.00	1	<.001
Yes	88.84	199	11.16	25			
No	75.99	364	24.01	115			
Assault characteristics							
Time since assault					12.56	4	<.05
<24 hours	83.97	393	16.03	75			
24–48 hours	73.85	96	26.15	34			
48–72 hours	72.58	45	27.42	17			
72 hours to 1 week	72.92	35	27.08	13			
>1 week	50.00	1	50.00	1			
Disclosure of assault before seeking health care							
Disclosed to law enforcement					101.49	1	<.001
Yes	93.01	386	6.99	29			
No	62.16	184	37.84	112			
Disclosed to family/friend					17.55	1	<.001
Yes	74.70	307	25.30	104			
No	87.67	263	12.33	37			
Any prior disclosure					6.46	1	<.05
Yes	80.84	561	19.16	133			
No	52.94	9	47.06	8			
Reasons for seeking health care							
STIs					15.27	1	<.001
Yes	71.74	165	28.26	65			
No	84.52	404	15.48	74			
Pregnancy					9.97	1	<.01
Yes	68.32	69	31.68	32			
No	82.37	500	17.63	107			
DNA collection					30.94	1	<.001
Yes	93.09	202	6.91	15			
No	74.75	367	25.25	124			
Pursue criminal investigation					75.77	1	<.001
Yes	95.42	292	4.58	14			
No	68.91	277	31.09	125			

Note. STIs = sexually transmitted infections.

SANE program were more likely to decline the MFE. It is not common for survivors to tell no one about the assault before seeking medical care or reporting to the police (Ahrens, 2006; Patterson et al., 2009), so providing additional support to these patients may be helpful. Linking survivors to advocacy services before and after the examination may be useful, and healthcare practitioners may need to spend extra time working with these patients throughout the MFE. Patients who had disclosed the assault to someone else, such as a victim advocate, the police, an intimate partner, family members, and/or friends, were more likely to consent to an MFE. These prior disclosures spanned both formal and informal support providers, which underscores the importance of strong professional networks across disciplines, and broad-based community education on post assault health care and the resources provided by SANE programs. The results of this study also revealed that patients' stated reasons for seeking SANE care were linked to their declination decisions. Patients who expressed concerns about injuries and those who wanted DNA evidence collection and criminal prosecution were more likely to consent to the MFE. However, our results support prior research indicating that not all patients want to pursue criminal justice options, and they can still seek post assault health care without reporting to the police (Heffron et al., 2014; Price, 2010; Zweig et al., 2014).

Patients who consent to an MFE may not consent to all parts of the examination. In this study, 19% of patients who had an MFE declined some component, which highlights how each step of the examination must be explained to and freely chosen by patients (Campbell et al., 2008). Victims were most likely to decline the use of a speculum during the examination, and although we do not have detailed information about why patients declined, it seems possible that speculum use may feel too invasive in post assault health care. Qualitative methods are well suited for capturing this kind of nuance, and future research should explore the nature of patients concerns with this—and other—components of the MFE. Consistent with prior qualitative work (Corrigan, 2013; Fehler-Cabral et al., 2011; Greeson & Campbell, 2011; Mulla, 2011, 2014; White & Du Mont, 2009), some patients were uncomfortable with photographic documentation, as this was the second most common option in the MFE to be declined. Again, future research should explore patients' concerns and the utility of forensic photography and its role in patient-centered, trauma-informed care.

Those who consented to an MFE (in full or in part) were highly likely to also consent to the collection of an SAK (99%). The small percentage of patients who declined this service noted that they did not want to go through evidence collection or pursue criminal prosecution. Interestingly, a sizable percentage of patients who sought care in these SANE programs did not specifically state that they were interested in pursuing criminal prosecution (59%), but they nevertheless agreed to kit collection. Given the quantitative nature of this study, we do not have much insight into why these survivors consented to SAK collection. Patients may have freely chosen to preserve evidence and keep options open for later deliberation (see Greeson & Campbell, 2011). Alternatively, as Corrigan (2013) reported, patients may have felt SAK collection was an explicit or implicit requirement of seeking care. Future research is needed to determine whether the high consent rates in this study replicate in other jurisdictions and why patients who may not seek MFEs primarily for legal reasons consent to SAK collection.

In the state in which this study was conducted, the release of a completed SAK to law enforcement for forensic testing is a separate decision for sexual assault patients. In 2014, new legislation was passed, the Sexual Assault Victims Access to Justice Act (Michigan Public Act 319 of 2014) and the Sexual Assault Kit Evidence Submission Act (Michigan Public Act 227 of 2014), after public outcry about the number of unsubmitted SAKs in police property storage facilities throughout the state (Campbell et al., 2015). This legislation sought to improve accountability for victims by formalizing the release of evidence to the police, which would then follow new mandated processes and timelines for forensic DNA testing (Sexual Assault Kit Evidence Submission Act, Michigan Public Act 227 of 2014). In this study, 80% of patients who had a completed SAK released the kit to the police, and those who sought SANE care because they wanted DNA evidence collection and to pursue criminal prosecution were more likely to release their kits. Twenty percent of the patients who had a kit collected did not consent to its release to law enforcement, with most indicating they wanted more time to consider this choice and many feeling they could not make such a weighty decision in their current emotional state. It was beyond the scope of this study to follow up on these cases to determine whether patients later released their kits for testing, and future research is needed on rates of delayed kit release and what factors prompted patients to have their kits tested.

In addition to the limitations with this study already noted, we acknowledge that we were unable to collect more detailed data about these patients, the focal sexual assault, and their healthcare services. The research team could not access patient files because of HIPAA, VAWA, and IRB regulations. These restrictions are appropriate as we are not clinicians, but they highlight the need for clinician-initiated research projects (e.g., Du Mont et al., 2014; Valentine et al., 2019) that often afford more opportunities for in-depth data collection/data extraction. Furthermore, we note that, although we collected data across seven sites that had markedly different community characteristics, we do not know whether these findings might generalize to other states with different policies and legislation regarding SAK collection and release. Replication research is warranted to understand how community context affects patients' decisions to decline services.

Implications for Clinical Forensic Nursing Practice

This study emphasizes the importance of clear communication from healthcare practitioners to patients about each step in the MFE and SAK, as well as allowing patients to decline services as they choose. Whereas our findings do not suggest a singular patient profile that is consistently associated with declination of services, our results suggest a few features clinicians should be mindful about when providing care. In this study, all patients were at least 18 years old, but those who were on the younger end of the age continuum were more likely to decline parts of the MFE and less likely to release the SAK to law enforcement. Likewise, patients who had disabilities were less likely to release their SAKs to the police for forensic testing. We do not know whether their declination was because of lack of information, or needing more time to process these weighty decisions, but SANE program staff may need to consider how to link these patients to advocacy services and other support providers to increase the network of individuals who can help victims evaluate their options.

Finally, patients have different reasons for seeking post assault health care—some are more health related, and some are more legally focused. We did not find a consistent one-to-one association such that patients who sought SANE care for health concerns were more likely to decline legally focused services, such as SAK collection, although rates of declination did vary (albeit inconsistently) by patients' reasons for seeking the examination. Nearly all patients in this study completed SAKs, and the vast majority released SAKs for testing, but it is not clear whether these decisions were always freely chosen or whether patients felt they must comply with these components. Practitioners need to understand patients' healthcare and legal goals, while being mindful that victims may change their minds throughout the course of SANE care, so practitioners must respect their decisions. Completing all parts of an MFE or SAK is not the penultimate objective of patient-centered care; rather, the goal is attending to patients' needs and empowering their choices.

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